Title: Understanding Structural Long-Term Care Racism

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Abstract: Socioeconomically marginalized groups, including racial minorities, receive lower quality long-term care (LTC) in the U.S. compared to the more affluent majority. Disparities include sub-standard nursing home care, impaired access to assisted living or home care and reduced or inferior medical treatments. Medicaid causes these deficiencies because it dominates LTC financing, but pays too little to ensure quality. Many scholars conclude the system is structurally racist. This paper examines the laws, regulations and policies that produce racially prejudiced LTC outcomes. Medicaid's financial eligibility rules devastate the poor but enable higher income individuals to qualify and preserve substantial exempt wealth. By retaining "key money" to pay privately at market rates before converting to Medicaid, the financially able access better facilities and services than are available to enrollees unable to pay. By indemnifying the nonneedy against LTC risk, Medicaid created a moral hazard that discouraged LTC planning and left most people dependent on public assistance when they face catastrophic care costs. The solution to structural LTC racism is to eliminate Medicaid's laws and regulations that benefit the affluent and disfavor minorities.

Main Text: Long-term care (LTC), also known as long-term services and supports, encompasses medical and custodial care in residential or institutional settings for people in need of assistance with activities of daily living due to frailty, disability or cognitive impairment. Socially and economically marginalized groups face impaired access to quality LTC in the United Sates. A rapidly expanding academic literature documents disparities of many kinds.

Blacks tend to reside in nursing homes that have "serious deficiencies, lower staffing ratios, and greater financial vulnerability."[1] Besides dubious nursing homes, the range of

deficiencies experienced disproportionately by Black, Indigenous, and persons of color (BIPOC) includes segregation;[1,2] reduced access or deficient home and community-based care,[3,4,5] assisted living,[6] mental health services,[7] pain medication,[8] influenza vaccinations,[9] hospital and hospice care[10] and ADRD (Alzheimer's Disease and Related Dementias) care;[11] more physical restraints[12] and pressure ulcers;[13] and higher COVID-19 incidence, hospitalization and death counts.[14,15]

Structural LTC Racism

What accounts for these inequities? The common denominator is Medicaid dependency.[16] Due to its dominance of LTC financing, contributing over half of the $438 billion the U.S. spent on LTC in 2022,[17] and its low reimbursement rates, far below private-pay levels and often less than the cost of providing the care,[18] Medicaid is responsible for most of the deficient access and quality that BIPOC patients receive. Because the long-term care system itself causes racial disparities, many sources attribute the problems to "systemic, structural or institutionalized racism."[19,20] Structural racism "operates through laws and policies that allocate resources in ways that disempower and devalue members of racial and ethnic minority groups, resulting in inequitable access to high-quality care."[21]

Residential segregation and poverty cause BIPOC LTC users to live disproportionately in poor neighborhoods. People with lower economic status who live in relatively impoverished neighborhoods with nursing homes that rely most heavily on Medicaid's meager reimbursements tend to be the ones who suffer most from structural LTC racism. Whites who depend on Medicaid are not immune to the same deficiencies afflicting marginalized enrollee groups. But Whites on the margin are more prosperous and less dependent on Medicaid. They tend to live in

areas with better private-pay LTC options, such as home care and assisted living, and with nursing homes that are less Medicaid dependent.[22]

Proposed Solutions for Structural LTC Racism

Proposals to eliminate or mitigate structural LTC racism center on improving Medicaid with better policies and more funding. One source calls for a multi-prong effort to add "disproportionate-share payment adjustments to nursing homes with a higher proportion of Medicaid residents" and to equalize "Medicaid and private-pay payments."[1] Another would "increase Medicaid and Medicare reimbursement rates, especially for providers serving high proportions of Medicaid-eligible and BIPOC older adults" and "expand access to Medicaid-waivered HCBS services."[20] These are worthy goals, but simply pouring more resources into Medicaid without eliminating the conditions that favor Whites over BIPOC patients would only deliver a better funded, but still structurally racist program.

Absent from the large body of peer-reviewed articles on structural LTC racism is much discussion of the specific "laws, policies, institutional practices, and entrenched norms" that disempower racial and ethnic minorities and cause the care disparities.[23] If Medicaid dependency triggers the LTC system's inequities and deficiencies, then the laws and policies governing Medicaid LTC eligibility should be a crucial topic for analysis. What are those laws and policies? What role do the rules governing access to Medicaid LTC benefits play? Do they benefit some and disadvantage others? If so, how are marginalized groups disempowered and devalued? Do prosperous people benefit disproportionately from Medicaid? If so, how?

Medicaid and Structural LTC Racism

Income and Asset Eligibility Rules

The most common statement about Medicaid LTC eligibility in both the popular and academic literature is that qualification requires low income and assets. Sources explain that income above $943 per month ($967 as of 2025) or assets exceeding $2,000 renders someone ineligible for the program. Applicants must "spend down" privately for care to those levels before they become financially eligible. In fact, however, Medicaid LTC financial eligibility is much less stringent.

Income is rarely an obstacle to eligibility because state Medicaid programs either deduct private health and LTC expenses before applying the low income standard or they permit applicants to divert excess income into trusts. Most states (34) use the "medically needy" income eligibility method.[24] They deduct private medical and LTC expenses from income before determining eligibility, enabling people to qualify despite having incomes well above categorical eligibility limits. Other states use an "income cap" method, allowing income up to 300 percent of the Supplemental Security Income monthly limit. People with much higher incomes can still qualify for Medicaid in income cap states by diverting excess income to an income diversion trust, also known as a "Miller" or "Qualified Income Trust."[25] A rule of thumb is that income below the monthly cost of a nursing home, easily $8,000 or $9,000, relatively high income, is not disqualifying.

Likewise, most large resources seniors own are exempt from Medicaid's asset limit. Exempt wealth includes a home and all contiguous property up to a minimum of $713,000 ($730,000 as of 2025) everywhere and a maximum of $1,071,000 ($1,097,000 as of 2025) or more in nine states,[26] but also, without any dollar limit, one vehicle, prepaid burial funds, a business including its capital and cash flow, personal belongings and household furnishings, even IRAs if they are in payout status as is usually true for elders in need of LTC.[25]

Medicaid Financial Eligibility and Structural LTC Racism

How do these facts about Medicaid LTC income and asset eligibility relate to structural LTC racism? Most low income, asset-poor people qualify for Medicaid LTC benefits quickly. They have little income and countable wealth to spend down and what they do have is consumed rapidly by private health and LTC expenditures. Medicaid LTC financial eligibility policy devastates people on the lowest rung of the wealth ladder.

Less understood is that many people with substantially greater wealth also qualify quickly and with little or no asset spend down required. Their biggest assets, such as home equity, are exempt already and their countable resources are easily converted to exempt status. They can "spend down" countable assets simply by purchasing a new car, home improvements or any other item on long lists of exempt assets available online,[25] or from attorneys specializing in Medicaid planning.[27]

Medicaid planners routinely qualify even wealthy clients for Medicaid LTC benefits by means of legal spend down avoidance strategies such as Medicaid asset protection trusts used "to protect assets from being counted for Medicaid eligibility;"[28] Medicaid-compliant annuities that convert "excess funds into an income stream with no cash value" to accelerate "Medicaid eligibility, while protecting your client's assets;"[29] life estates "to preserve your residence and increase your Medicaid eligibility,"[30] or half-a-loaf methods. "Half a Loaf, Reverse Half a Loaf, and Modern Half a Loaf are Medicaid gifting strategies (also called transfer strategies) … used for the purpose of reducing countable assets to qualify for Medicaid. These strategies can also preserve some of the Medicaid applicant's assets for their family members."[31] California's Medi-Cal program recently eliminated its limit on countable assets altogether making LTC benefits available regardless of wealth and obviating the need for sophisticated legal spend down strategies.[32]

One effect of this system is that middle-class and affluent people qualify for Medicaid LTC benefits as easily as the poor and with less financial disruption. Once qualified, all use Medicaid's LTC benefits. When people of moderate or substantial wealth qualify for Medicaid, they consume scarce resources that would otherwise have benefited people of lesser means. Such expanded coverage depletes Medicaid's scarce resources and reduces the range and quality of care available to others on the program, especially BIPOC enrollees.

But why would people who could purchase high quality LTC in the private market prefer to qualify for Medicaid instead? Is it only to save money? Or could they somehow capture the best care Medicaid has to offer to the exclusion of more disadvantaged enrollees? How biased is Medicaid-based structural LTC racism?

Key Money[33]

It seems counter-intuitive that individuals and families with significant wealth would choose to use Medicaid even when that path is legally available to them given the program's reputation for substandard access and quality. The reason they do is one of the many ways structural LTC racism manifests in the LTC marketplace.

Some nursing homes have relatively few Medicaid beds. Such facilities often have supplemental philanthropic funding and comparatively high private-pay or Medicare resident census.[1] They enjoy the higher financial margins that come from those sources' relatively more generous reimbursements. Such facilities often provide better care and services because of their higher revenue and lesser dependency on low Medicaid rates. This two-tier system benefits those who can access it, but disadvantages any, including many BIPOC enrollees, who cannot.[16]

Because the Medicaid reimbursement rate for nursing home care is approximately 70 percent of what private payers pay,[34] skilled nursing facilities eagerly seek out new admissions

who can pay privately from day one and for at least some period of time before they convert to Medicaid.[1] Medicaid planners encourage their affluent clients to hold back enough countable wealth, so-called "key money," from the Medicaid spend down process so they will be able to pay privately for care at the start "to facilitate the admission of the Medicaid applicant to the best long-term care facility available."[35] Once admitted, nursing homes cannot evict patients simply because their source of payment changes from private pay to Medicaid.[36,37]

Because socioeconomically disadvantaged groups lack key money, they end up in the less desirable Medicaid-only or mostly Medicaid facilities. More prosperous White enrollees tend to live in areas with the best LTC facilities and they possess the key money to buy their way in. This result is unfair, unethical, and structurally racist, but commonplace.[38]

Moral Hazard

Beyond consuming Medicaid resources that could have gone to economically marginalized people, the availability of Medicaid LTC benefits to individuals of higher financial means has another negative, systemic consequence. In effect since Medicaid began operating in 1966, this system created a moral hazard—"a situation in which people or organizations do not suffer from the results of their bad decisions, so may increase the risks they take."[39] The result of making Medicaid LTC eligibility available late in life while allowing significant wealth to be divested or retained in exempt form is that too many people fail to plan for LTC.[40] They end up consuming Medicaid resources instead. Why save, invest or insure early in life against needing LTC someday in old age when the government covers catastrophic costs if such care is needed and reserves the best publicly financed care for the most economically well-off people? This harmful incentive discourages early, responsible LTC planning by relatively prosperous people. It underwrites structural LTC racism.

Roots of Structural LTC Racism

Medically Needy Eligibility

From the beginning, Medicaid LTC benefits were available not only to the financially destitute, those meeting the strict financial qualifications for state welfare payments or Supplemental Security Income (SSI), but also to the medically needy. The medically needy are people with too little income to pay for institutional or home-based LTC, but with too much income to qualify for cash assistance. These higher income people are not excluded from Medicaid eligibility based on income if their private health and LTC expenses are high enough or they use an income diversion trust. The result is that people with significant incomes end up relying on Medicaid. The same people preserve wealth in the form of exempt assets. While such assets are vulnerable to mandatory estate recovery, few states enforce that requirement effectively and the liability is easy to avoid with some early legal planning.[41]

Law makers' well-intentioned plan to help more people with LTC disinclined everyone to prepare personally for LTC risk and overloaded the public assistance program with enrollees. Medicaid LTC tried to do too much for too many so it does too little for most, especially for BIPOC enrollees with the greatest need. That is the root of structural LTC racism.

LTC Financing and Racism

Medicaid LTC enrollees are required to contribute most of their income to offset the program's cost for their care. As Medicaid reimbursement rates are only about two-thirds of private-pay rates, enrollees get a substantial discount on their care.[34] But LTC providers are short-changed. They receive only the Medicaid rate, often less than the cost of the care, instead of the higher private-pay rate even though enrollees are paying "out-of-pocket" from their incomes, largely from their Social Security benefits. It sometimes happens that enrollees' incomes are higher than

Medicaid's rate for their care. In those cases, Medicaid pays nothing; the enrollee pays all; and the LTC provider struggles financially with most of its revenue coming from the lowest payors' rate. As the structural LTC racism literature often observes, low Medicaid reimbursements cause care deficiencies and inequities. These occur because of the laws and policies that govern Medicaid LTC eligibility and financing.

A Solution for Structural LTC Racism

If the cause of structural LTC racism is too many enrollees with sheltered or divested wealth overwhelming Medicaid's ability to pay for quality care, then the solution must lie in diverting more prosperous people away from Medicaid dependency, enabling them to pay privately for LTC, and thus empowering Medicaid to afford better care for those most in need who remain eligible. But that is a tall order. It presents two major challenges: (1) how to keep people with significant wealth off Medicaid so more program resources reach the people currently shortchanged by structural LTC racism, and (2) how to prepare the middle class and affluent to pay for their own LTC when they need it after Medicaid is no longer available to pay for their care and preserve their wealth as now.

Re-targeting Medicaid to end structural LTC racism

Knowing how to exclude higher-income/higher-asset people from Medicaid LTC so that more program resources reach the disadvantaged is not difficult. Simply repeal the Medicaid laws, regulations and policies that permit them to qualify. Medically needy income eligibility rules that allow higher income people to qualify if their private health and LTC expenses are high enough should end. Practically unlimited asset exemptions, such as for home equity, that permit people with any amount of wealth to qualify must go. Spending down by purchasing exempt assets instead of paying for care should cease. Medicaid strategies such as special trusts, annuities,

spousal refusal, and life estates—legal gimmicks that enrich lawyers and their affluent client heirs—must stop as well. Easing the path to Medicaid's best LTC options by means of key money should end. Stopping structural LTC racism cannot be achieved until Medicaid is preserved exclusively for the most disadvantaged, whom its laws and policies have hurt the most historically.

But these needed changes are much more difficult to achieve politically than they are to identify and list. People who benefit from the status quo will fight to preserve and expand the current system and structure. These interested parties include (1) most Americans who remain oblivious to LTC risk and cost because easy access to Medicaid LTC late in life has enabled their denial; (2) elder law attorneys and financial planners who profit from transitioning prosperous clients to the best of Medicaid-financed care; (3) politicians who garner votes by promoting easy access to Medicaid LTC benefits; (4) LTC analysts and economists who ignore the extensive legal literature on Medicaid planning and pretend the practice of artificial impoverishment does not occur, and (5) the state and federal health and human services bureaucracies that have strived to expand Medicaid LTC to everyone, especially the White middle class, instead of targeting it to the victims of structural LTC racism. These are the people and the reasons that sustain the LTC status quo and stand in the way of reform, consistently protecting structural LTC racism whether consciously and intentionally or not.

Conclusion

Structural LTC racism causes reduced access to quality LTC for marginalized groups. It is grounded in Medicaid LTC eligibility law, regulations and policies. By enabling middle class and affluent people to access Medicaid LTC late in life, and preserve exempt wealth, the program became overloaded with people who should, could and would otherwise have prepared

privately for LTC risk and cost. Medicaid covered too many enrollees with too many benefits ensuring that those most vulnerable financially would receive the program's deficient care, while others more privileged, in possession of key money, would gain access to the best care the program offers.

The good news is that this condition is reversible. Lawmakers should end access to wealth-preserving Medicaid LTC benefits late in life. Instead, offer creative methods for families in mid-life to prepare responsibly to pay privately when and if they ever need expensive extended care. Some possibilities include allowing individuals and families to meet individually set LTC saving goals by carving out portions of other wealth they are accumulating, such as from retirement savings, home equity, life insurance or estate planning. Implement such measures and enormous, desperately needed private funds will flow immediately into the LTC service delivery system ensuring better access to higher quality care for everyone. Relieved of financing LTC for the middle class and affluent, Medicaid will be able to pay adequately to ensure quality care for all enrollees, ending the long-standing system of structural LTC racism.

Why this goal is realistic and how to achieve it are topics for another paper.

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